TPPA should not be adopted without a full, independent health assessment

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The Trans-Pacific Partnership Agreement (TPPA) between 12 Pacific Rim countries (Australia, Brunei Darussalam, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, the US and Vietnam) was agreed and its text finally made available in late 2015. The Agreement is long and complicated, and contains 30 chapters, many annexes and multiple side-letters. The National Interest Analysis released by the New Zealand Government indicates that while current health-relevant policies will continue, future governments will face constraints in developing new policies. The New Zealand Medical Association, the World Medical Association and the Director General of the World Health Organization (WHO) have identified concerns about the health consequences of trade and investment agreements. In this paper we synthesise some of the interim independent expert commentary on the released TPPA text.

Global challenges for health and well being

Greater wealth usually goes along with greater health, dramatically so for least wealthy countries. But it’s not a simple relationship. Health depends on the way increased wealth is shared and used, and if everyone benefits from technologies such as adequate housing, sanitation, nutrition, occupational health, education and medical treatments.

So too with global trade and investment. Our lives are better for the import of vaccines, hip joint replacements, coffee, solar power and housing insulation technologies—but as with national wealth, more is not necessarily better. Indiscriminate imports can be appalling for health. Narcotics forced into China by the British (plus French and Americans) in the opium wars stands out. This century, the World Trade Organization (WTO) insisted that Pacific countries import high-fat turkey tails and mutton flaps and that the US take clove-flavoured tobacco products, with inevitable negative health consequences.

In the same way that commerce is sometimes bad for health, measures to protect and improve health have at times forced commerce to adapt. When John Snow famously persuaded the authorities to close the pump that was making cholera-ridden water available on London’s Broad Street in 1854, businesses that relied on this water had to find another water source or go broke. Similarly, health regulatory measures on lead, laudanum and occupational health and safety have all saved lives, yet have also curtailed industry profits and closed businesses. Businesses and communities had to find healthier things in which to invest.

In this century, climate change caused by human greenhouse gas pollution looms as the greatest global health threat. Tobacco, obesity and alcohol are huge global and national health issues. In New Zealand, all are powerful drivers of inequality in health, especially for Māori. Reduced carbon emissions, healthier foods, and decreased tobacco and alcohol use would all bring improved health, yet also lower sales, trade and profitability for some businesses.

The challenge for all countries is to transition to healthier commerce. Often regulations to protect or promote health have a cost to one industry while opening up commercial opportunities for others. Examples include regulations about worker safety, and reducing the burning of coal; the former creates opportunities for manufac-
turers of safety equipment, while the latter for innovators of clean, renewable technologies. We need trade and investment agreements to support these transitions, implementing WHO and United Nations (UN) Sustainable Development Goals, treaties and instruments, and ensuring governments respond to health threats as evidence emerges. The government’s own National Interest Analysis and initial independent expert analyses all indicate that the TPPA fails to contribute to healthy trade in a number of important ways.

**Strengthening powers of global commerce**

Almost all the TPPA chapters relevant to health expand on existing WTO provisions and these expanded provisions will become the new baseline. The New Zealand Government’s analysis says:

*The new obligations would, however, place new limitations on the Government’s ability to modify New Zealand’s policy settings to ensure they are appropriate for our domestic circumstances.*

The existing WTO rules on trade and investment give foreign countries opportunities to dispute and overturn government policies. Even threats of a dispute at the WTO can delay and limit government decisions. In 2010, New Zealand, Australia and others argued that Thailand’s planned health warning labels for alcohol could pose an additional barrier for alcohol trade.15 As a consequence, Thailand’s alcohol warning labels were delayed by 5 years, and modified.16

The TPPA expands WTO dispute processes to further protect trade, investment, intellectual property monopolies and expectation of profit (Dispute Settlement Chapter 28). Disputes between countries are heard by off-shore panels. There is a requirement that dispute panel members have appropriate expertise when a dispute involves the labour, environment or anti-corruption chapters, but not health. Health advocates have no inherent right to make submissions; technical advice from health experts can be sought only if the complaining country agrees. If the panel rules against a health-protecting policy, the government is required to remove the policy or face financial or other sanctions.

In addition to these rights for foreign countries, the TPPA gives rights to foreign companies as soon as they take concrete action to invest (Investment Chapter 9). Investment is broadly defined to include brand names, logos, patents and more. Several TPPA chapters (such as Regulatory Coherence Chapter 25, Transparency and Anti-Corruption Chapter 26, Technical Barriers to Trade Chapter 8) give foreign companies greater influence in the formation, operation and review of regulation for the purpose of “facilitating increased trade”.

Foreign companies also become entitled to dispute government actions via Investor-to-State Dispute Settlement (ISDS). Offshore *ad hoc* tribunals judge these disputes and can order the government to pay compensation. There is no right of appeal or review.

Many existing international agreements include ISDS provisions which have generated disputes. ‘*Eli Lilly* (a US pharmaceutical company) versus the Canadian government’ is ongoing. The dispute arose after Canada declined to extend a medicine monopoly patent because the company’s own data showed that the drug did not work for the claimed extended indications.17 In the well-known ‘*Philip Morris versus the Australian government*’, Australia reportedly spent over A$50 million in the first phase of defending tobacco plain packaging legislation. The case was closed on technical grounds, not because plain packaging was ruled a legitimate public health measure.18 At the end of a long regulatory process, the US declined an application for the Keystone XL petroleum pipeline from Canada’s tar sands on environmental grounds (particularly climate change). ‘*TransCanada versus the USA*’ is beginning, with US$15 billion claimed in damages, using the ISDS provisions in the North American Free Trade Agreement.19

The TPPA text fails to meet the call of the World Medical Association for a prohibition on ISDS in relation to policies that promote or protect health.4 However, some small concessions were made to the United Nations’ suggested reforms to ISDS,20 placing some limits on ISDS and prohibiting secrecy seen in the past. Further, the TPPA...
does not meet the investment standard set by the European Parliament, to protect from ISDS any measures related to the Paris climate change agreement.21

New Zealand currently has some agreements that include ISDS. However, we have not previously had a trade agreement incorporating ISDS with the US, where companies are the most prolific in taking ISDS suits.20

Generic protections for healthy public policy are fragmented, inconsistent and weak

The TPPA does contain a number of provisions that governments can use to defend healthy public policies against foreign country or foreign company disputes (see Technical Barriers to Trade Chapter 8, Investment Chapter 9 and Annex 9B, Intellectual Property Chapter 18, Exceptions Chapter 29, Annex II New Zealand). However, the defences for health are illogical, incoherent and incomplete. The following illustrate this incoherent picture.

Some clauses state a principle, some are for “protection”, others for “preservation”, others relate to “problems”, or offer “sensitivity to objectives”. Some are for “health”, others for “public health”. Human life, safety, nutrition and availability of medicines are sometimes named separately from health. While this messy terminology may reflect ignorance and piecemeal drafting, the vague wording of these health clauses contrasts with the precise language used in other areas of the Agreement (such as the explicit, extraordinarily broad definition of “investment” and the careful elaboration of other terms in the text to reduce doubt in interpretation). These ambiguous provisions could open governments to threats, delay tactics and disputes from foreign countries and foreign companies. It is far from clear how these unclear clauses would support, for example, the obesity and alcohol measures recommended by the New Zealand Medical Association.22,23

Each health-related protection applies to a select chapter or provision. There are appendices that permit specific existing country-specific policies and laws to continue. For example, a New Zealand appendix permits regulations on tobacco and alcohol wholesale and retail sales—but this protection does not extend to the regulation of advertising of tobacco and alcohol. The provision cannot be applied more widely (eg, to regulation on retail sale of junk food), or by other TPPA countries.

Other health protections are either weak or circular. Some follow WTO wording, despite the general failure of WTO protections to support governments’ health or environmental policies. Judgements on WTO disputes to date have often decided that health-protecting regulations were not “necessary”, as a more trade-friendly (but less health desirable) alternative could be found.24 In other chapters, exceptions for government health measures are only defended from dispute if they are consistent with everything else in that chapter. Finally, some health protections may not apply in (undefined) “rare circumstances”.

Specific additional protections for pharmaceuticals and tobacco control

During the TPPA development, tobacco and pharmaceuticals were the health issues in greatest contention. It seems that even Trade Ministers agreed that there are holes in the generic protection for healthy public policies, because in these particular areas they negotiated extra protections.

Tobacco’s prominence is a consequence of persistent and aggressive use of trade and investment treaties by the tobacco industry to delay, undermine and reverse governments’ actions to implement the decade-old WHO treaty, the Framework Convention on Tobacco Control (FCTC). The TPPA does not recognise the existence of the FCTC. Foreign countries may use obligations in many different chapters to take a government to an international arbitration panel to reverse actions to implement the FCTC.25 In direct opposition to the FCTC, in which countries have agreed to reduce the influence of tobacco companies on government policy, the TPPA expects
governments to include foreign companies in policy-making with no mechanism to exclude tobacco (see Transparency Chapter 8, Regulatory Coherence Chapter 25).

There is a significant tobacco control protection, thanks to the efforts of the Malaysian government negotiators and health professionals the world over. This provision (Exceptions Chapter 29.5) may limit the ability of foreign tobacco companies to sue a government for loss of profit because of smokefree policies. However, this protection is not automatic (a government has to explicitly invoke it) and the protection only applies to manufactured (not leaf) tobacco.

The focus on pharmaceuticals during the TPPA development arises from the long-standing pressure from patent-holding pharmaceutical companies to extend monopoly periods. Increased intellectual property provision threatens access to medicines (including biological medicines), particularly for developing countries. For wealthier countries, schemes such as PHARMAC that have successfully driven down medicines costs and progressively replaced brand-name medicines by cheaper generics (or biosimilars) have been opposed by brand name manufacturers and countries acting on their behalf.

The TPPA brings longer exclusive monopoly periods for new medicines before a competitor’s generic (or biosimilar) medicine can be made available (Intellectual Property Chapter 18 Subsection C). Additional intellectual property obligations will lead to delays for many countries in the availability of generics, with resulting increased medicines costs. There are complicated mechanisms to ensure market monopoly for biologics, a group of medicines never before given special protections in a trade agreement. For many countries these obligations will dramatically reduce access to affordable medicines. While the TPPA affirms parties’ rights to take measures to protect public health as set out in the Doha Declaration on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and Public Health, some provisions in the intellectual property chapter actively undermine access to affordable medicines by extending and expanding monopoly rights. It appears decisions on medicines subsidies will be protected from direct dispute. Foreign countries cannot seek reversal of medicines subsidy decisions, nor can foreign companies directly seek compensation. However, they may be able to dispute the effect of those decisions on investments via other TPPA chapters.

For New Zealand, the TPPA provides increased opportunities for foreign pharmaceutical companies to question and seek review of PHARMAC’s funding decisions. These provisions concerning medicines are located in Transparency and Anti-Corruption Chapter 26. Some obligations are new, such as patent term extensions, patent linkage and aspects of biologic medicines market exclusivity. They will reduce future policy flexibility. The extent to which they will affect medicines costs for the government will depend on the ways in which the obligations are interpreted.

**Implications for other health threats**

Evidence-based WHO and UN international agreements reflect the cooperation of many governments to limit disease by protecting the physical environment, and controlling hazardous products or behaviours. The only health-related international agreement explicitly supported in the TPPA is the Montreal Protocol on Substances that Deplete the Ozone Layer (Environment Chapter 20). Its inclusion is a ‘win for health’ (eg, skin cancer and cataracts), and demonstrates that the TPPA could recognise other health-related agreements. The text is totally silent on other health-protecting UN/WHO agreements, including the following:

- 1948 Universal Declaration of Human Rights (including the right to health —progressively attaining conditions which enable people to be healthy)
- 2010 WHO Global strategy to reduce harmful use of alcohol
- WHO Global action plan for the prevention and control of noncommunicable diseases 2013–2020
- 2007 UN Declaration on the Rights of Indigenous Peoples
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- 1992 UN Framework Convention on Climate Change and subsequent international agreements
- 2015 UN Sustainable Development Goals.

The newly signed Paris Agreement under the UN Convention on Climate Change (UNCCC) has the potential to be a major global breakthrough in tackling climate change, and may be the most important agreement for public health this century. Climate change, greenhouse gases and the UNCCC do not rate a mention in the TPPA, although countries agree to “co-operate” on undefined “emissions”. It is difficult to see how countries that ratify the current text of the TPPA will translate the Paris Agreement into effective laws and policies.

The TPPA has many chapters relevant to both food and alcohol. Nutrition is mentioned once (Intellectual Property Chapter 18), but as separate from public health. It will take considerable time until independent analyses of the implications for these areas are available.

Conclusions

Vital for 21st century healthy trade are investment agreements that support policies to underpin health, equity and human rights, the transition to a low-carbon economy and environmental protection. The New Zealand Medical Association and others have repeatedly called for independent health impact assessment of trade and investment deals, in-line with concerns from the World Medical Association, the Director General of the WHO and many United Nations human rights experts.

The TPPA is long, complicated, and interconnected. Comprehensive assessment is required of its broad impacts on health and equity. The initial independent health-focused analyses reported here indicate that the TPPA offers negligible support for implementation of UN and WHO health and human rights agreements, while enhancing the investment interests of foreign companies. While the TPPA appears to allow some regulatory freedom, the New Zealand Government’s own analysis highlights that it places limitations on government’s future policy options.

These concerns are sufficiently serious that decisions on implementation and ratification should be delayed until full and more comprehensive independent analysis of health impacts is available for public and Parliamentary scrutiny.

Competing interests:
Joshua Freeman, Gay Keating, Erik Monasterio and Pat Neuwelt are foundation members of Doctors for Healthy Trade. Joshua Freeman, Gay Keating, and Alexandra Macmillan are Executive Board members of OraTaiao: The New Zealand Climate and Health Council. Pat Neuwelt is a co-sponsor for the Public Health Association of New Zealand’s Policy on Trade and Health.

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